

(3) If the outcome of the grievance procedure is adverse to a client, the provider shall notify the person of his or her right to appeal to the department under the department's fair hearing procedure. (History: Sec. 53-20-204, MCA; IMP, Sec. 53-20-205, MCA; NEW, 1979 MAR p. 1711, Eff. 12/28/79; TRANS, from SRS, 1998 MAR p. 3124.)

Additional clarification related to dispute resolution:

Disputes related to the denial of-eligibility for services could result in a request for a DDP administrative review and, depending upon the outcome, a Department fair hearing. Parents of children who do not meet the eligibility requirements for CAW services would learn of their right to appeal and fair hearing rights via the E&D contractor's letter of ineligibility. For families of children enrolled in the waiver, the plan of care serves as the basic forum for dispute resolution. The plan of care is designed to address all facets of a service recipient's life. Typically, the provider internal grievance policy is enacted when there is failure to achieve IFSP team consensus on an issue affecting the child or family. Adverse actions not resolved by the provider's internal grievance policy would lead to a DDP administrative review and ultimately, a Department fair hearing. The client always retains the right to proceed directly to Department fair hearing, as outlined on the DDP Waiver-5 form.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System. Select one:**

☒ **No. This Appendix does not apply**

☐ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:**

**c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. Select one:**

☒ **Yes. The State operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)**

☐ **No. This Appendix does not apply (do not complete Items b through e)**

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents**

(including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Incident Management Policy and the DDP Incident Management System handbook is the reference source providing the following information. Reporting requirements are references in Montana Codes Annotated and the Administrative Rules of Montana, below.

53-6-401, MCA  
41-3-101 through 41-3-446, MCA  
ARM 37.42.1501 through ARM 37.34.1513

All staff reimbursed with waiver funds in the provision of services to the child are mandatory reporters. When such staff suspect abuse, neglect or exploitation, staff are obligated to report to Child Protective Services (CPS) as soon as possible, and always within 8 hours. The child's case manager would be notified within 8 hours. The DDP QIS would be notified within 24 hours. An incident report would be written and submitted within two days to the DDP QIS and to the child's case manager. The investigative authority is CPS.

Critical incidents must be reported to the DDP QIS and the child's case manager within 24 hours and 8 hours, respectively, when the staff person is responsible for the care and supervision of the child (e.g., no parents are in the home) at the time of the critical incident. In this event, the staff person must complete an incident report and submit the written report to the DDP QIS and the child's case manager within 2 days. Critical incidents involving the emergency hospitalization or death of the child when abuse, neglect or exploitation is not suspected are reported by the staff person to the DDP QIS within 24 hours and to the child's case manager within 8 hours. In these cases, written incident reports are submitted to the DDP QIS and the case manager within 2 days. Critical incidents involving death and emergency hospitalizations are subject to investigations. The investigative authority for children served in the waiver is the agency employing the child's case manager when CPS is not involved.

A copy of the DDP Incident Management Policy effective 7/1/08 is available upon request.

For the purpose of this policy, critical incidents shall be defined as follows:

**1. Aspiration/Choking**

**Definition:** The inhaling of food or other object in the lung (aspiration) or choking.

This includes, any aspiration or choking incident that results in staff assistance, (e.g. "stomach thrusts") or emergency medical intervention by an emergency medical technician, physician, nurse practitioner, physician's assistant.

**2. Death**

**Definition:** All loss of life, regardless of cause.

**Critical Incident:** All consumer deaths are to be treated as a critical incident and reported no later than eight (8) hours after the death occurred to identified authorities as outlined by this policy.

**3. Discovery of Illegal or Hazardous Substances**

This includes, any incident involving the use of or the discovery of illegal or hazardous substances or items, where the service provider has a duty to inform law enforcement due to possible criminal violations of law, e.g. discovery of illegal drugs/drug paraphernalia, weapons, etc.

**4. Hospitalization**

**Critical Incident:** Any unplanned admission to a hospital, clinic or other medical facility as a result of an illness or medical condition for surgery, medical observation, treatment, or testing; and any planned or unplanned psychiatric hospitalization.

## 5. Medication Error

### a. Physician or Pharmacy Error

- Incorrect drug selection, contraindications, known allergies, harmful interaction with existing drug therapy;
- Incorrect dose, dosage form, quantity, route, concentration, rate of administration; and/or
- Illegible prescription(s) or medication order(s) that lead to errors.

### b. Incorrect Administration:

- Medication administered in a dose other than prescribed by the physician (greater than or less than);
- Inappropriate procedure or technique for administering the medication, e.g. wrong texture, consistency, position, or other specified procedures;
- An incorrect route of administration, or one which has not been prescribed;
- Administration of a drug that has expired or for which the physical or chemical dose (integrity of the drug) has been compromised; and/or
- Consumer's refusal to take the medication and follow medication regimen after reasonable efforts have been made to encourage the person to take the medication.

### c. Omission/Missed Dose:

- Medications not administered because the medication was omitted, sufficient quantities were not available, or not filling prescriptions within a reasonable amount of time; and/or
- The failure to administer a prescribed medication for one or more dosage periods;

### d. Wrong Time:

- Medication administered early or late; and/or
- Medication administered outside a predefined time interval from its scheduled administration time (time intervals should be established by each service provider).

### e. Unauthorized Dose:

- Medication not authorized by a physician for the consumer;
- Medication given to the wrong person;
- Administering medication beyond a "stop order"; and/or
- Administering medication prescribed to treat behaviors without consent from the parent or guardian;

### f. Training and Documentation Errors:

- Incorrect documentation of medication orders, e.g. label on bottle does not match information on the Medication Administration Record (MAR);
- Administering medication but failing to document the MAR correctly;
- Failure to follow other agency procedures for medication administration; and/or
- Medication administered by unauthorized and/or improperly trained staff.

### g. Other:

- Finding medication in an inappropriate area, e.g. in a person's clothing, on the floor, packaged with a meal, in non-secure area, in an unmarked/open container or dish, mixed together in a container, etc.;
- Security/storage safeguards are not followed; or
- Failure to notify other service providers involved in supporting the consumer of new/changes in medication orders.

**Critical Incident:** Medication Errors are classified as Critical Incidents when the following conditions occur in relation to the examples cited above:

- Consumer evidences serious adverse side effects;
- Consumer's life, health or welfare is in jeopardy due to the above listed actions or inactions; and
- Consumer is either treated at a hospital emergency room or medical clinic;
- Consumer is admitted to a hospital; or
- Medications are discovered missing where there is likelihood that the medications may be sold or used illegally.

**Notes:** DPHHS/DDP must be notified of all Critical Medication Errors within eight (8) hours.

Regardless of whether a consumer has experienced adverse side effects and/or their health/welfare is in jeopardy, certain types and/or patterns of medication errors emerging from regular trend analysis of all medication errors may raise the incidents to a Critical Incident classification. As a result, service providers should respond as such and initiate investigations into those circumstances (e.g. has possible neglect occurred).

## 5. Injury

**Critical Incident:** Injuries of unknown origin that require assessment and/or treatment by a physician, physician assistant, nurse practitioner, dentist, or other licensed healthcare practitioner including, but not limited to:

- a. fractures;
- b. lacerations requiring sutures, use of derma bond, or staples;
- c. third degree burns;
- d. electric shock;
- e. loss or tearing of body part;
- f. all eye emergencies;
- g. ingestion of toxic substance; and/or
- h. any injury with loss of consciousness.

Note: If the injury is suspected to have been caused by abuse and/or neglect, the injury should be reported under the appropriate incident category and notifications made to proper oversight authorities including DDP, APS, CPS, law enforcement, etc.

#### 6. Mechanical Restraint

Critical Incident: The following are to be reported as a Critical Incident when they allegedly occur:

- a. Use of restraint vests, camisoles, Posey Vests, body wraps and chairs for behavioral reasons;
- b. Removing a consumer's mobility aids (wheelchairs, walkers, etc.) to prohibit freedom/choice of movement unless otherwise delineated through the consumer's PSP;
- c. Mechanical restraints that impair or inhibit visual or auditory capabilities or prevent, inhibit, or impair speech or other communication modalities; and/or
- d. Any use of a mechanical restraint occurring in a community program where the person is receiving services funded through the DDP without an approved Level II program, as provided in ARM 37.34.1401 through 1408.

#### 7. Physical or Manual Restraint

Critical Incident: Physical or manual restraint practices prohibited by this policy identified below are to be reported as a Critical Incident when they allegedly occur:

- a. Take Downs;
- b. Physically forcing an individual to a ground or other surface.
- c. Prone Restraints;
- d. Holding an individual face down in a horizontal position;
- e. Using restraints as punishment;
- f. Using restraints for the convenience of staff;
- g. Using restraints as a substitute for treatment or care in conflict with a physician's order;
- h. Using restraints in quantities which inhibit effective care/treatment; and/or
- i. Any use of a physical restraint occurring in a community program where the person is receiving services funded through the DDP without an approved Level II program, as provided in ARM 37.34.1401 through 1408.

#### 8. Use of PRN Medication for Behavior

Definition: A chemical substance used for the control of a problem behavior which, when administered in a given dosage, results in a decrease or the elimination of the behavior.

Critical Incident: The following use of PRN medications is considered a Critical Incident and require reporting to the DDP Regional Office within one (1) business day: emergency or PRN usage of psychotropic medications, when the medication is not a part of a protocol or program plan or if there is reason to suspect that the protocol or program plan was not followed.

#### 9. Use of Exclusionary Time Out

Definition: "Exclusionary Time Out" means a method of decreasing a maladaptive target behavior by requiring a consumer to leave an ongoing reinforcing situation for a period of time, contingent on the occurrence of some previously specified maladaptive target behavior.

Note: While the use of "time out" is a concern in adult services, time out is considered an accepted practice for good parenting and parents with children who exhibit challenging behavior are typically taught methods of appropriately implementing time out procedures as an alternative to the use of punishment. Therefore, the use of time out by a parent receiving child and family services is not considered an incident under this policy unless abuse or neglect of

the child is suspected. Child and family providers who fail to provide instruction to parents may also be considered negligent under this policy.

**Critical Incident:** Any use of Exclusionary Time Out occurring in a community program where the person is receiving services funded through the DDP without an approved Level II program, as provided in ARM 37.34.1401 through 1408.

#### 10. Use of Seclusion Time Out

**Definition:** "Seclusion Time Out" means a method of decreasing a maladaptive target behavior by requiring a person to leave an ongoing reinforcing activity and go to a closed room for a period of time. Seclusion Time Out is contingent on the occurrence of some previously specified maladaptive target behavior. The room to which the person must go must not be reinforcing in any manner.

**Note:** While the use of "time out" is a concern in adult services, time out is considered an accepted practice for good parenting and parents with children who exhibit challenging behavior are typically taught methods of appropriately implementing time out procedures as an alternative to the use of punishment. Therefore, the use of time out by a parent receiving child and family services is not considered an incident under this policy unless abuse or neglect of the child is suspected. Child and family providers who fail to provide instruction to parents may also be considered negligent under this policy.

**Critical Incident:** Any use of Seclusion Time Out occurring in a community program where the person is receiving services funded through the DDP without an approved Level II program, as provided in ARM 37.34.1401 through 1408.

#### 11. Suicide Threats or Attempt

**Critical Incident:** A consumer's verbal, non-verbal or written threat to kill him/herself. An incident involving an act (attempt) to harm, injure or kill oneself, whether or not the person actually injures or causes death to him/herself.

#### 12.-16. Allegations of Abuse to the Consumer

**Definition:** "Abuse" means:

- (a) the infliction of physical or mental injury; or
- (b) the deprivation of food, shelter, clothing, or services necessary to maintain the physical or mental health of an older person or a person with a developmental disability without lawful authority (MCA 52-3-803).

**Note:** Any individual who comes in contact with a consumer, including an employee, contractor, intern, volunteer, visitor, family member, a consumer or legal representative whether or not the involved consumer is, or appears to be, injured or harmed, may be alleged to have abused a consumer. However, it must be remembered that while the intent of this policy is to protect consumers from harm, it is not intended to be a mechanism to substitute for the proper recording of behavioral problems of consumers, including behaviors of consumers who are aggressive or assault others. Incidents involving consumer-to-consumer interactions that constitute abuse, as defined by this policy, will be reported and investigated as abuse.

Therefore, an aggressive act of a consumer towards another consumer that resulted in an injury would first be reported as abuse and subsequently as staff abuse or neglect, if an investigation revealed that it was due to an alleged action or inaction on the part of an employee.

**Critical Incident:** All incidents involving allegations of abuse are automatically elevated and treated as Critical Incidents. The Service Provider is expected to implement protocols defined by this policy in response to the allegations including reporting the incident to identified authorities external to the Service Provider organization, including DDP, APS, CPS, and/or law enforcement within required timeframes and initiating a Critical Incident Investigation unless otherwise instructed.

#### 12. Abuse Allegation Involving Physical Injury to the Consumer

**Definition:** "Physical Injury" means death, permanent or temporary disfigurement, or impairment of any bodily organ or function. (MCA 52-3-803) "Temporary disfigurement" means bruises, lacerations or any visible skin injuries.

**Critical Incident:** Any incident involving an allegation of Physical Injury, as defined above, is automatically elevated and treated as a Critical Incident.

### 13. Abuse Allegation Involving Mental Injury to the Consumer

**Definition:** "Mental Injury" means an identifiable and substantial impairment of a person's intellectual or psychological functioning or well-being. (MCA 52-3-803)

**Critical Incident:** Any incident involving an allegation of Mental Injury, as defined above, is automatically elevated and treated as a Critical Incident.

### 14. Abuse Allegation Involving Exploitation of the Consumer

**Definition:** "Exploitation" means:

(a) the unreasonable use of an older person or a person with a developmental disability or of a power of attorney, conservatorship, or guardianship with regard to an older person or a person with a developmental disability in order to obtain control of or to divert to the advantage of another the ownership, use, benefit, or possession of or interest in the person's money, assets, or property by means of deception, duress, menace, fraud, undue influence, or intimidation with the intent or result of permanently depriving the older person or person with a developmental disability of the ownership, use, benefit, or possession of or interest in the person's money, assets, or property;

(b) an act taken by a person who has the trust and confidence of an older person or a person with a developmental disability to obtain control of or to divert to the advantage of another the ownership, use, benefit, or possession of or interest in the person's money, assets, or property by means of deception, duress, menace, fraud, undue influence, or intimidation with the intent or result of permanently depriving the older person or person with a developmental disability of the ownership, use, benefit, or possession of or interest in the person's money, assets, or property;

(c) the unreasonable use of an older person or a person with a developmental disability or of a power of attorney, conservatorship, or guardianship with regard to an older person or a person with a developmental disability done in the course of an offer or sale of insurance or securities in order to obtain control of or to divert to the advantage of another the ownership, use, benefit, or possession of the person's money, assets, or property by means of deception, duress, menace, fraud, undue influence, or intimidation with the intent or result of permanently depriving the older person or person with a developmental disability of the ownership, use, benefit, or possession of the person's money, assets, or property. (52-3-803, MCA)

**Critical Incident:** Any incident as defined above involving an allegation of Exploitation is automatically elevated and treated as a Critical Incident.

### 15. Allegation of Neglect of the Consumer

**Definition:** "Neglect" means the failure of a person who has assumed legal responsibility or a contractual obligation for caring for an older person or a person with a developmental disability or who has voluntarily assumed responsibility for the person's care, including an employee of a public or private residential institution, facility, home, or agency, to provide food, shelter, clothing, or services necessary to maintain the physical or mental health of the older person or the person with a developmental disability. (MCA 52-3-803)

**Critical Incident:** Any incident as defined above involving the suspicion of or allegation of neglect is automatically elevated and reported as a Critical Incident.

### 16. Allegation of Sexual Abuse of the Consumer

**Definition:** "Sexual abuse" means the commission of sexual assault, sexual intercourse without consent, indecent exposure, deviate sexual conduct, or incest, as described in Title 45, chapter 5, part 5. (MCA 52-3-803)

**SEXUAL ASSAULT:** Knowingly subjecting another person to any sexual contact without consent.

**SEXUAL INTERCOURSE WITHOUT CONSENT:** Knowingly having sexual intercourse without consent with another person

**INDECENT EXPOSURE:** Knowingly or purposely exposing the person's genitals under circumstances in which the person knows the conduct is likely to cause affront or alarm in order to:

(a) abuse, humiliate, harass, or degrade another; or

(b) arouse or gratify the person's own sexual response or desire or the sexual response or desire of any person.

**DEVIATE SEXUAL CONDUCT:** Knowingly engaging in deviate sexual relations or who causes another to engage in deviate sexual relations.

**INCEST:** (1) Knowingly marrying, cohabiting with, having sexual intercourse with, or having sexual contact with an ancestor, a descendant, a brother or sister of the whole or half blood, or any stepson or stepdaughter. The relationships referred to in this subsection include blood relationships without regard to legitimacy, relationships of parent and child by adoption, and relationships involving a stepson or stepdaughter.

(2) Consent is a defense under this section to incest with or upon a stepson or stepdaughter, but consent is ineffective if the victim is less than 18 years old.

**Critical Incident:** Any incident as defined above involving an allegation of Sexual Abuse is automatically elevated and reported as a Critical Incident.

#### 17. Allegation of Mistreatment of the Consumer

**Definition:** The use of practices which are:

- a. Contra-indicated by a consumer's Individual Plan/Individualized Treatment Plan;
- b. Which do not follow accepted treatment practices and standards of care in the field of developmental disabilities; and/or
- c. Are not allowed as described within the laws or regulations of the State of Montana. This includes, but is not limited to the following:
  1. Use of any aversive procedure including use of:
    - stimuli, activities, or sprays/inhalants that are, or may be considered noxious, intrusive, or painful;
    - Use of electric shock;
    - Water sprayed into the face;
    - Pinches and deep muscle squeezes;
    - Shouting, screaming or using a loud, sharp or harsh voice to frighten or threaten;
    - Use of obscene language;
    - Withholding of adequate sleep;
    - Withholding of adequate shelter or bedding;
    - Withholding bathroom facilities;
    - Withholding of warm clothes;
    - Withholding meals, essential nutrition or hydration; and/or
    - Use of facial or auditory screening devices;
  2. Use of psychotropic medication, or behavioral intervention used to decrease inappropriate behavior which has not been approved by the Developmental Disabilities Program Review Committee and/or the provider agency's Human Rights Committee in compliance with laws or regulations of the State of Montana prior to implementation;
  3. Removal of a consumer's personal property as punishment;
  4. Unobserved time-out room or area used solely for time-out; and/or
  5. Use of chemical restraint instead of positive programs or medical treatment.

**Critical Incident:** Any incident as defined above involving an Allegation of Mistreatment is automatically elevated and reported as a Critical Incident.

Individuals required to report critical events via an incident report form are persons reimbursed with waiver funds for the provision of services. Paid staff are responsible for reporting critical incidents when these staff are solely responsible for the supervision and support of the child.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

#### Children's Services

In children's services, parents are the primary care givers. Child and Family providers are responsible for training staff to recognize the signs and symptoms of abuse, and to have the skills necessary to report abuse in accordance with the DDP Incident Management Policy requirements.

Providers must have internal policies designed to support DDP's Incident Management Policy. The DDP annual QA

review process will review provider policies ensuring that required policies are in place.

The Service Provider's internal Incident Management System must include the following elements:

1. Procedures for promptly identifying and reporting incidents as defined by Appendix A: Definitions of Reportable and Critical Incidents;
2. A requirement for prompt staff intervention when knowledge of harm, or the potential for harm, occurs;
3. Procedures for the prompt review of the incident for purposes of initially classifying the event and determining the need for a critical incident investigation;
4. Procedures for prompt medical assessment and/or treatment, or contact with necessary community support personnel as required;
5. A requirement that any injury(s) suspected to be caused by abuse, neglect, or mistreatment be immediately examined by a medical professional and classified as an allegation of abuse, neglect, or mistreatment for reporting purposes;
6. A requirement for timely and accurate notification of the incident to appropriate staff, guardians, public officials and representatives from other agencies;
7. Procedures for prompt assignment of agency staff to conduct critical incident investigations;
8. Initiation of an Incident Report Form (IR) for any injury sustained by the consumer during the use of any exclusionary time-out, physical or mechanical restraint, or emergency psychotropic medication, even if specified in an approved behavior support plan;
9. Procedures for conducting reviews of incidents and implementing corrective action(s) to prevent the recurrence of similar incidents;
10. Procedures for data collection and conducting trend analysis as a means to develop appropriate support and service plans for the consumer(s) to prevent more serious incidents from occurring, as specified in Appendix B;
11. Requirements for prompt personnel actions when warranted;
12. Establishment of an Incident Management Committee, either a new committee or in combination with a currently established committee such as a Human Rights or Safety Committee, as specified in Appendix B to this policy;
13. Procedures identifying the role and function of the committee including routine review and assessment of all Reportable and Critical Incidents, monitoring trends of incident report information, and developing policies and procedures designed to protect and prevent harm to consumers;
14. Procedures requiring weekly meetings of the agency's Incident Management Committee, as specified in Appendix B to this policy;
15. Procedures to assure that reports of incidents and any required documentation including Incident Report Forms, trend analysis reports and Critical Incident Investigation Final Reports are:
  - a. Allowed to be received from any individual having knowledge of Reportable and Critical Incidents as defined by this policy;
  - b. Kept confidential, and that the names of those who report Reportable and Critical Incidents are not released without the permission of the person who made the report, unless required by law;
  - c. Presented in a standardized format provided by the Developmental Disabilities Program;
16. Procedures for including a summary of incident report information and trend data, as well as the results of investigations, in the consumer's confidential records, as appropriate, in the employee's personnel records and submitted to the Quality Improvement Specialist of DDP;
17. A requirement that any employee of the provider, the family, or the State, who is responsible for direct care

services to individuals with disabilities receive in-service training required by DPHHS/DDP in the elements of the Service Provider's Incident Management System including methods of prevention, detection, intervention, reporting, and investigation of consumer incidents; and

18. Procedures for the Service Provider to initiate and conduct a formal internal Critical Incident Investigation by staff. Service Providers are required to initiate and conduct Critical Incident Investigations or to cooperate with investigators from outside agencies where:

- a. The Regional Manager of DDP determines that the investigation will be conducted by DDP staff;
- b. The Developmental Disabilities Program completes and/or participates in, or conducts a parallel investigation. These instances include any incident that results in emergency hospitalization of the consumer and any incident that results in the death of a consumer; or
- c. Other agencies or entities, such as, law enforcement, Adult Protective Services (APS), Child Protective Services (CPS), Bureau of Indian Affairs (BIA), Mental Disabilities Board of Visitors, DPHHS Certification Bureau, DPHHS Licensing Bureau, etc., which are required by statute or regulation to conduct the investigation into the incident, determine that their staff will conduct the investigation. Disability Rights Montana also may conduct an independent investigation and has access to certain records, pursuant to 42 USC Sec.15043.

In addition to the above, the following assurances apply:

\*Abuse Prevention Training has been provided to Child and Family service provider staff on a limited basis by DDP training staff in the DDP abuse prevention curriculum. A copy of this curriculum is available upon request.

\*Staff (case management and training staff) working directly with autistic children must be familiar with the signs and symptoms of abuse, neglect, and exploitation and must know how to report suspected abuse. The knowledge and skills of these staff will be assessed via a staff survey process as part of the DDP Quality Assurance Review process. Deficiencies will be addressed via a QAOS sheet, which would require the provider to acknowledge the problem, and to develop a solution (often, the scheduling of additional training) designed to increase the skills of direct service staff in this critical health/safety area.

\*Parents will be asked by the DDP QIS how they would respond in the event they witnessed training staff working with their child in a manner which made them uncomfortable.

All of the above monitoring activities will be included in the first DDP QA annual review of waiver-funded service providers.

- d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Please review G-1.b, above. The DDP QIS will review the incident report for purpose of either developing a QAOS sheet, or ensuring the provider is conducting an investigation of the incident, if required by the Incident Management Policy. Additional details follow:

1. All Critical Incidents, as defined by this policy and by statute or regulation, require notification to authorities external to the organization. This notification is to occur verbally and/or in writing (through the IR) and generally on an immediate basis as defined (see Appendix C: Critical Incident Notifications Grid).
2. The consumer's Case Manager must be notified of Critical Incidents including deaths, suicide attempts, unaccounted for absences, emergency hospitalization, and law enforcement involvement, by the Service Provider immediately and no later than eight (8) hours from the time the incident is identified. For the purposes of this requirement, notification can mean contact with the person via phone or in person, email, voice mail message, pager, or fax. Proper documentation of method of notification must be completed on the IR Form (see the "Notification Grid" section of the IR Form).
3. The Regional Quality Improvement Specialist must receive verbal notification of Critical Incidents that involve allegations of client-to-client abuse causing physical injury, client-to-client abuse causing mental injury and client-to-client sexual abuse as soon as possible.
4. The Regional Quality Improvement Specialist and the consumer's advocate must receive verbal notification of Critical Incidents including deaths, suicide attempts, unaccounted for absences, emergency hospitalizations, and law

enforcement involvement from the Service Provider within 24 hours of the incident being identified. For the purposes of this requirement, notification can mean contact with the person via phone or in person, email, voice mail message, pager, or fax. Proper documentation of method of notification must be completed on the IR Form (see the "Notification Grid" section of the IR Form).

5. Verbal notification of Critical Incidents within 24 hours should be made available to other Individual Plan/Individualized Treatment Plan members and/or parents, family members, advocates, guardians, with proper releases, if they have requested that this occur.

6. The consumer's Guardian must receive notification of Critical Incidents involving deaths, suicide attempts, unaccounted for absences, emergency hospitalizations, and law enforcement involvement from the Service Provider as soon as possible and no later than eight (8) hours after the incident is identified. For the purposes of this requirement, notification can mean contact with the person via phone or in person, email, voice mail message, pager, or fax. Proper documentation of method of notification must be completed on the IR Form (see the "Notification Grid" section of the IR Form).

7. Service Providers must assure that policies and procedures for the agency's Incident Management System reflect protocols supporting the conduct of competent investigations when Critical Incidents have been identified (See Appendix E: Guidelines for Conducting Critical Incident Investigations).

8. The Service Provider will generally be expected to initiate and conduct a critical incident investigation when a Critical Incident has been reported. There will be exceptional circumstances arising that require the Critical Incident Investigation be conducted by an entity external to the organization, or in tandem with another provider where an individual is being served jointly by two or more providers. Examples of these circumstances include, but are not limited to:

- Incidents involving possible infractions of criminal law and the law enforcement/criminal investigation takes precedence;
- Incidents involving allegations against a Service Provider's Executive Staff and/or member(s) of the Board of Directors;
- Incidents where the Developmental Disabilities Program will complete and/or participate in, or conduct a parallel investigation, including any incident that results in emergency hospitalization of the consumer and any incident that results in the death of a consumer; and/or
- Other circumstances that due to the nature and/or sensitivity of the allegation require that an investigator not affiliated with the organization conduct the investigation.

In these circumstances the Service Provider should ensure when notifying the Department of Public Health and Human Services, Developmental Disabilities Program, DPHHS Licensure Bureau, Adult Protective Services, Child Protective Services, and/or law enforcement that these concerns are communicated so proper guidance and decisions can be made for all parties regarding initiation of the investigation.

9. The Critical Incident Investigation Final Report (CIIFR) or Critical Incident Team Report (CrITR) should be documented in the format provided by the Department of Public Health and Human Services/Developmental Disabilities Program. A copy of the completed IR Form is to be included with the final report.

10. The Critical Incident Investigation is to be completed no later than five (5) working days after reporting the incident. An extension of no more than five (5) working days may be granted to the 5-working-day period. The extension must be requested of, and approved in writing by, the Developmental Disabilities Regional Manager.

11. At the conclusion of the investigation, a copy of the CIIFR or CrITR is to be forwarded to the following:

- a. Executive Director of the Service Provider that initiated the investigation, who will forward the report to the Agency's Board of Directors;
- b. Other Executive Staff, as appropriate, of the Service Provider that initiated the investigation; or
- c. For MDC, the Executive Staff includes: Superintendent, Deputy Superintendent and Administrative Service Director.

12. The CIIFR or CrITR is to be made available to the parties listed below:

- a. DPHHS/DDP Executive Staff including: Director of the Developmental Disabilities Program, the Community Services Bureau Chief, Regional Manager of the Region in which the incident occurred, Quality Improvement

Specialist; and

b. As appropriate, designated legal staff for the Department, and other agencies as required by law or regulation for Critical Incidents.

13. The Service Provider must also assure that the consumer or their guardian, and the consumer's Case Manager are notified of the outcome of the investigation by providing written documentation (i.e. a written summary) of the findings.

An important component of the new Developmental Disabilities Program Incident Management System policy is the classification of harm, or incidents, consumers may experience while receiving services. The Developmental Disabilities Program Incident Management System policy requires that all Service Providers have an incident management system that functions as an important part of any internal quality management process of an organization providing services and support to people with disabilities. For the purpose of the Incident Management System policy, incidents are classified into two (2) levels: Reportable Incidents and Critical Incidents, as defined in Appendix A of the policy. The policy requires that all events identified as Reportable and Critical Incidents will be reviewed as specified in the Incident Management System policy through the organization's internal quality management processes. Additionally, events classified as Critical Incidents are required to be reported externally to designated authorities, and investigated according to the Developmental Disabilities Program Incident Management System Policy following the Guidelines for Conducting Critical Incident Investigations. In addition, where the reporting staff person or supervisor has reasonable cause to suspect that the consumer has been subjected to abuse, sexual abuse, neglect, or exploitation as defined by the Montana Elder and Persons with Developmental Disabilities Abuse prevention Act (52-3-801, et. Seq., MCA), the incident is required to be reported to the Department with additional information.

## II. Key Requirements of the Developmental Disabilities Program Incident Management System Policy and Protocol for Conducting Critical Incident Investigations

1. Based upon the nature of the incident that occurred, and as defined by statute and Montana Code, and the Developmental Disabilities Program Incident Management System Policy, the Service Provider is responsible for notifying various parties including, but not limited to, the Developmental Disability Program, the consumer's guardian, Case Manager, and advocate, Adult or Child Protective Services (APS/CPS), law enforcement, DPHHS Licensure Bureau, and/or Disability Rights Montana. See the Incident Management System Policy, Appendix C: IMS Policy Notifications Grid for specific detail regarding parties to be notified and required timeframes for reporting.

2. The Service Provider will generally have primary responsibility for conducting critical incident investigations occurring at their agency. However, in certain instances, the Developmental Disabilities Program will complete and/or participate in, or conduct a parallel investigation. These instances include any incident that results in emergency hospitalization of the consumer and any incident that results in the death of a consumer. The investigator will have five (5) working days to complete the investigation, including submission of the fully completed incident report form (in the case of MDC, investigations must be completed within five (5) working days due to Federal ICF/MR regulations). An extension to the 5 working day period must be requested and approved in writing by the Developmental Disabilities Regional Manager.

3. Developmental Disabilities Program will review critical incident investigations completed by service providers using the Critical Incident Investigation Competency Assessment Tool (see attachment). The Developmental Disabilities Program Quality Improvement Specialist will complete the Assessment Tool review within five (5) working days of receiving documentation of the investigation, including the Final Investigation Report. Where the Critical Incident Investigation is conducted by the Quality Improvement Specialist and involves emergency hospitalization or client death, the review will be conducted by the Program Support Bureau Chief. When the QIS conducts the investigation for other Critical Incidents, the review will be performed by the Regional Manager. If the five (5) working days requirement cannot be met, documentation and justification will be submitted to Developmental Disabilities Program Regional Manager. Based upon this review, Developmental Disabilities Program may request further follow-up or investigation of the incident.

4. All staff assigned to conduct a formal critical incident investigation under the Developmental Disabilities Program Incident Management System Policy are required to participate in a critical incident investigation training. The Developmental Disabilities Program will provide, at least annually, a course on conducting critical incident investigations to ensure that Service Providers have sufficient personnel to conduct investigations.

5. The Developmental Disabilities Program has developed a "Conducting Critical Incident Investigations" curriculum

- for training investigators and will be responsible for the maintenance of the curriculum.
- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The details involving the oversight activities may be reviewed in the DDP Incident Management System. In brief, the following applies:

The Incident Management System policy requires the compilation of data by region, by corporation and by individual.

Overview of the provider specific incident information occurs at scheduled weekly service provider meetings (can be cancelled if no incidents occurred) of the State Qualified Provider Incident Management Committees. The purpose of these meetings is to ensure that efforts are made to reduce the likelihood of similar incidents occurring in the future. A casemanager representative for recipients served by the provider are required to attend these weekly meetings. In addition, a DDP QIS, the provider Incident Management Coordinator, the Director of the service provider agency or his designee and representatives of the provider's operational program units will attend the weekly meetings.

The provider is responsible for submitting a monthly Incident Management Trend Summary of Critical Incidents to the provider Board of Directors and the Quality Improvement Specialist. In addition, a provider annual report must be submitted to the same individuals summarizing the committee reviews and the actions taken.

Overview of this information at the DDP central office level includes a designated staff person reviewing the results of all critical incident investigations, and providing technical assistance to persons and agencies involved in the investigations.

The Incident Management Policy requires that every provider of services develop and implement an Incident Management Committee. Those requirements follow:

All service providers are required to establish an Incident Management Committee (the Committee). The purpose of the Committee is to provide an immediate and focused program and management assessment of harm or the potential for harm, consumers may experience while receiving services provided by the organization.

1. The Committee membership must include:

- a. The Executive Director/CEO or the Executive Director/CEO's designee;
- b. Incident Management Coordinator;
- c. Representatives of each of the service provider's operational program units;
- d. The DDP Quality Improvement Specialist assigned to work with the agency; and
- e. A Case Management representative.

Note: Within the above requirements, service providers have the discretion in the titles of staff assigned to the Committee, but they are required to assure that the Committee's membership as a whole includes adequate managerial, clinical, direct support and rehabilitative staff to carry forward the Committee's functions.

A. REGULAR FUNCTIONS OF THE COMMITTEE:

2. The Committee must meet at least weekly. If there are no incidents and/or review of previous incidents, then the committee does not need to meet as scheduled.
3. At each meeting, the Committee is required to review the following:

a. All Incident Report Forms of internal reportable and critical incidents that have been reported since the last scheduled meeting, that is, during the previous week.

b. The review is focused on:

- ☐ review of what occurred and the staff response and follow-up actions
- ☐ determination of whether already recommended corrective/preventive actions were implemented;
- ☐ Consideration of what (if any) additional corrective and/or preventive actions are warranted that would provide additional positive supports to the service recipient and staff;
- ☐ Consideration of whether the consumer's Targeted Case Manager should be contacted to discuss possible

revisions to the Individual Plan/Individualized Treatment Plan, based on additional information developed as a result of this process.

☐ The Committee is responsible for assuring that the Incident Report Form is completed at the time the incident is reviewed by the committee.

4. The Committee is responsible for maintaining minutes of the meetings. The minutes should include:

- a. Names, titles and agency represented of those in attendance; and
- b. Documentation of the Committee's findings, recommendations, implementation of recommendations, and results/effects of actions implemented. A sample form for documenting minutes is attached to the end of this appendix.

Note: The Committee's minutes have the same level of confidentiality as an Incident Report Form and both must be available to Department of Public Health and Human Services/Developmental Disabilities Program for review and/or copying as requested.

5. Within 15 days of a Critical Incident being reported and investigated by the agency the Committee (or a smaller sub-group) should review any Critical Incident Final Investigation Reports (CIIFR's) and Critical Incident Team Reports (CrITR's) that have been completed. These reviews must focus on:

- a. Reviewing the initial Critical Incident reported;
- b. Reviewing the critical incident investigation for competency and thoroughness;
- c. Determining the final conclusions and recommendations to close the critical incident investigation.
- d. Documentation of the Committee findings provided to management of the Service Provider for review and implementation; and
- e. Reviewing the status of implementation of recommendations identified in previous Committee meetings regarding investigation outcomes.

6. Review of the service provider's overall trends related to the Incident Management System policy requirements on a monthly basis. The trend data must include, but not be limited to information generated through the following:

- a. Committee review of incidents;
- b. Periodic High Risk Review process conducted by the Committee;
- c. Monthly Trend Summary Reports prepared by the service provider's Incident Management Coordinator; and
- d. Prepare recommendations, including necessary system changes, to present to the agency's management and Board of Directors (or Board of Trustees).

## B. SPECIFIC FUNCTIONS OF THE COMMITTEE

1. Review at least weekly all Reportable and Critical Incidents reported through the Service Provider's Incident Management System (IMS) by assessing the need for further interventions and supports to the consumer(s) and staff to improve the agency's capacity to protect people from harm. If there are no incidents to review as defined by this policy in a given week, the Service Provider may simply document this fact as reason why the Incident Management Committee did not meet.

2. Develop and monitor the implementation and effectiveness of corrective action taken for all Reportable and Critical Incidents reviewed by the Incident Management Committee.

3. Review the Incident Management Coordinator's monthly analysis of the Incident Management Trend Summary of Critical Incidents. The committee will review at minimum the following:

- i. Total number of incidents;
- ii. Types of incidents, including internal, reportable and critical;
- iii. Types of incidents by consumer name;
- iv. Causes of incidents;
- v. Incidents by total number of injuries;
- vi. Severity of injuries;
- vii. Location where injuries and other incidents occur;
- viii. Shifts, if applicable, on which injuries and other incidents occur;
- ix. Specific employees involved in the incident;

- x. Specific consumers involved in the incident; and
  - xi. Other trends deemed as being appropriate, based on the needs of consumers and the mission of the Service Provider.
4. The Incident Management Committee is responsible for submitting the Incident Management Trend Summary of Critical Incidents, along with completing an annual report relating to their review and actions taken, to the following:
- a. Service Provider's Board of Directors (monthly report);
  - b. Service Provider's Human Rights Committee (monthly report); and
  - c. Regional Quality Improvement Specialist (monthly report).

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

**a. Use of Restraints or Seclusion. (Select one):**

**The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

**The use of restraints or seclusion is permitted during the course of the delivery of waiver services.**

Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Note- Restrictive procedures used by child and family service providers in natural homes are based on the desires of the parent and agreed upon by the child's planning team. Restrictive procedures are considered procedures of last resort. The aversive rules referenced in this section apply to, and govern the conduct of, waiver-funded staff providing services to the client.

Assessment of maladaptive, aggressive, or other inappropriate behavior is referenced in Appendix C for the staff person providing Program Design and Monitoring (PDM). The basis for the treatment of these behaviors is the functional analysis of the behavior (under what conditions does the behavior occur, and how does behavior serve the need of the client) and non-aversive behavior intervention strategies. Any aversive program using physical or mechanical restraint, or time out, cannot be approved by the reviewing authority (the Developmental Disabilities Program Review Committee) in the absence of documentation indicating that less restrictive procedures have been diligently used and have failed to modify the behavior. The PDM service is provided by the staff person who would be developing proposed training/treatment plans incorporating the use of aversive procedures. The training and educational requirements for staff providing this service may be reviewed in Appendix C. The Children's Autism Training staff person would be implementing the formal training protocols and procedures with the child. The education and training requirements for this person are outlined in Appendix C.

The use of restraints and time out is governed in accordance with ARM 37.34.1401 through 37.34.1428, except the use of medications to control behavior is not governed under these rules. Medications may be used in accordance with the review of the IP team and the individual's physician or psychiatrist.

Physical and mechanical restraint, and seclusion time out procedures are considered interventions of last resort. Their use as either emergency procedures or as part of an ongoing Level 2 behavior program is

outlined in the previously referenced ARMs. These procedures may be used on an ongoing basis only when reviewed and approved by the Developmental Disabilities Program Review Committee (DDPRC). The DDPRC Standard Operating Procedures policy governs the disposition, scope, and authority of the committee. The DDPRC Guidelines for Level II Programs defines the contents of a referral packet when a provider is seeking to implement a Level II procedure. Use of emergency procedures employing restraint or time out is subject to the requirements of ARM 37.34.1420.

#### 37.34.1420 AVERSIVE PROCEDURES: EMERGENCY PROCEDURES

(1) Emergencies are those situations for which no approved individual program plan exists and which if not dealt with may result in injury to the client or other persons or significant amounts of property destruction.

(2) If an emergency occurs the service provider may apply the following techniques as necessary to bring a person's behavior under control:

(a) Physical restraint;

(b) Exclusion time-out; or

(c) Seclusion time-out in a room that conforms to the minimum requirements established by the developmental disabilities program review committee (DDPRC) and, that has been approved by the regional manager prior to use.

(3) All instances of the use of emergency procedures must be reported, in writing, to the regional manager within 48 hours. Such reports shall include at a minimum the time and date of the incident, the persons involved, the type and duration of the incident, a description of the cause(s) leading to it, any witnesses to the incident, the procedures employed, and other significant details. If an emergency procedure is used three times in a 6 month period, a written individual program plan must be developed. (History: Sec. 53-2-201 and 53-20-204, MCA; IMP, Sec. 53-20-203 and 53-20-205, MCA; NEW, 1986 MAR p. 345, Eff. 4/21/86; AMD, 1993 MAR p. 1356, Eff. 6/25/93; TRANS, from SRS, 1998 MAR p. 3124.)

In addition to the applicable rules, the Incident Management Policy and DDP Incident Management System outlines the provider and State staff reporting and investigation responsibilities when mechanical restraint, physical or manual restraint, PRN medications, seclusion and exclusion time out is used.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The use of restraints or seclusion time out fall broadly into two categories; use as emergency procedures and use in approved behavior support plans.

#### Emergency Use

Providers are responsible for reporting the incidents as outlined in the Incident Management Policy and in the ARMs governing the use of these procedures. The DDP QIS and the provider are responsible for tracking the frequency of emergency procedures and complying with the requirements set forth in ARM 37.34.1420 (see previous section). The ongoing use of emergency procedures requires the ongoing involvement of the planning team, and potentially, the development of an approved behavior support plan to address the behavior requiring the use of the emergency procedures.

#### Approved Behavior Support Plans

Any proposed use of physical, mechanical, exclusion or seclusion time out is contingent upon the initial approval of the recipient's planning team. Support programs employing Level II programs as defined in ARM 37.34.1410 require the initial and ongoing approval of the Developmental Disability Program Review Committee (DDPRC) as outlined in the previous section. Staff must be certified prior to the implementation of the behavior support plan. Certification is contingent upon staff demonstrating competence in the procedures and correctly answering oral questions pertaining to the support plan. The DDPRC may remand approval authority for level II programs to the DDP Regional Manager. The Chairperson of the DDPRC is a designated DDP central office staff person, familiar with formal training programs based on applied behavioral analysis. The applicable ARM language governing level II deceleration programs and the DDPRC follow:

- (3) Level II aversive procedures.
  - (a) Level II aversive procedures include:
    - (i) restitutional and positive practice overcorrection;
    - (ii) contingent exercise;
    - (iii) nonexclusionary time out;
    - (iv) exclusion time-out;
    - (v) seclusion time-out;
    - (vi) required relaxation;
    - (vii) contingent observation with restraint or with over 20 minutes duration each episode or 60 minutes total duration in a 24 hour period from midnight to midnight;
    - (viii) physical restraint;
    - (ix) mechanical restraint; and
    - (x) satiation.
  - (b) Level II aversive procedures are the most restrictive employed in the habilitation process and as such they may only be used:
    - (i) as part of a written IPP developed in accordance with the provisions of this chapter;
    - (ii) with the approval by the person's individual planning team including a division representative;
- (iii) with the initial review and approval by the developmental disabilities program review committee (DDPRC);
- (iv) with the ongoing review and approval by the regional manager; and
- (v) with the written consent of the person's parent if the person is under 18 years of age, or the person's legal guardian, if one has been appointed by the court.
- (c) The developmental disabilities program review committee (DDPRC) will respond in writing at its regularly scheduled meeting regarding requests for level II aversive procedures approval.
- (d) The following information must accompany any request for level II aversive procedures approval in order to be considered:
  - (i) documentation of individual planning team approval of the procedure;
  - (ii) a copy of the proposed individual program plan which conforms to the requirements specified in these rules;
  - (iii) documentation of the failure of less restrictive procedures including data from previous individual program plans and a brief summary of each procedure that has been used. In the absence of such documentation, strong justification for the use of aversive or deprivation procedures and an explanation for the lack of documentation must be supplied;
  - (iv) written endorsement from a physician for any procedure which might affect the person's health; and
- (v) written consent from the person's parent if the person is under 18 years of age, or the person's legal guardian, if one has been appointed by the court.
- (e) The regional manager must review and approve or disapprove level II procedures on an ongoing basis in accordance with the provisions of the rules of this subchapter.
- (f) The regional manager may request that the developmental disabilities program review committee (DDPRC) review a level II procedure, if a more thorough review may be warranted or if the level II procedure is changed significantly from the initial review by the developmental disabilities program review committee. (History: Sec. 53-2-201 and 53-20-204, MCA; IMP, Sec. 53-20-203 and 53-20-205, MCA; NEW, 1986 MAR p. 345, Eff. 4/21/86; AMD, 1993 MAR p. 1356, Eff. 6/25/93; TRANS, from SRS, 1998 MAR p. 3124.)

Rules 11 through 14 reserved

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37-7514 12/31/98 ADMINISTRATIVE RULES OF MONTANA

#### DEVELOPMENTAL DISABILITIES PROGRAM 37.34.1415

**37.34.1415 AVERSIVE PROCEDURES: DEVELOPMENTAL DISABILITIES PROGRAM REVIEW COMMITTEE** (1) The developmental disabilities program review committee (DDPRC) is a standing committee appointed by, and responsible to, the division administrator. The committee shall have representatives from at least the following three disciplines:

- (a) legal - a person with a degree in jurisprudence from an accredited law school;
- (b) advocacy/consumer - a trained advocate or the parent/guardian of a developmentally disabled person; and

(c) habilitation - a person with extensive education and experience in the use of the principles of applied behavior analysis in the habilitation of persons with developmental disabilities.

(2) The function of the DDPRC is to:

- (a) provide for initial review and approval of proposed level II aversive procedures in accordance with the rules of this subchapter;
  - (b) either remand the ongoing review and approval of the approved procedure to the regional manager or retain the ongoing review and approval of the approved procedure;
  - (c) review a sample of the level II procedures that are the responsibility of the regional managers in order to provide feedback to the division administrator regarding the reliability and appropriateness of the ongoing level II procedure reviews and approvals; and
  - (d) annually review the ongoing review process for level II procedures in each of the regional offices and make recommendations to the administrator concerning the conduct of the level II procedure reviews and approvals by the regional offices;
  - (e) periodically complete ongoing data reviews and approvals of a sample of level II procedures in lieu of the regional manager in order to facilitate ongoing involvement of the DDPRC in programs the committee initially approved; and
  - (f) publish and update as needed guidelines for the use of aversive procedures.
- (3) The DDPRC shall publish, maintain and disseminate the following information:
- (a) a list of the current members of the DDPRC;
  - (b) a schedule of the routine time and place of meetings;
  - (c) the name and mailing address of a contact person for the committee;
  - (d) a set of descriptors which specifies guidelines for the minimum elements of each type of aversive procedure in level II. Each descriptor shall be based on a review of the professional literature and contain a justification for each element specified;

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#### 37.34.1415 DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

- (e) a set of operating procedures for the committee;
- (f) a set of reliability procedures for the review of a sample of the level II aversive procedures approved on an ongoing basis by each regional manager;
- (g) guidelines for the periodic review of ongoing level II aversive procedures;
- (h) a brief application form to accompany all requests for program review; and
- (i) a description of the process for resolving appeals. (History: Sec. 53-2-201 and 53-20-204, MCA; IMP, Sec. 53-20-203 and 53 20 205, MCA; NEW, 1986 MAR p. 345, Eff. 4/21/86; AMD, 1993 MAR p. 1356, Eff. 6/25/93; TRANS, from SRS, 1998 MAR p. 3124.)

Rules 16 and 17 reserved

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#### 37-7518 12/31/98 ADMINISTRATIVE RULES OF MONTANA DEVELOPMENTAL DISABILITIES PROGRAM 37.34.1420

37.34.1418 AVERSIVE PROCEDURES: RESTRICTION OF ANY CLIENT RIGHTS (1) The following rights may not be restricted for the purposes of an aversive program:

- (a) the right to education and training services;
- (b) the right to reside, work and receive treatment in a safe environment;
- (c) the right to an individual plan;
- (d) the right to prompt medical and dental care;
- (e) the right to a nourishing, well-balanced diet;
- (f) the right to acquire the assistance of an advocate;
- (g) the right to the opportunity for religious worship; and
- (h) the right to just compensation for work performed. (History: Sec. 53-2-201 and 53-20-204, MCA; IMP, Sec. 53-20-203 and 53 20 205, MCA; NEW, 1986 MAR p. 345, Eff. 4/21/86; AMD, 1993 MAR p. 1356, Eff. 6/25/93; TRANS, from SRS, 1998 MAR p. 3124.)

37.34.1419 MEAL DELAY (1) No meal may be delayed for a period greater than 1 hour from its

scheduled starting time due to the implementation of an individual program plan. In no instance may a person miss a regularly scheduled meal as a result of the implementation of an individual program plan. (History: Sec. 53-20-204, MCA; Sec. 53-20-203 and 53-20-205, MCA; NEW, 1986 MAR p. 345, Eff. 4/21/86; TRANS, from SRS, 1998 MAR p. 3124.)

#### 37.34.1420 AVERSIVE PROCEDURES: EMERGENCY PROCEDURES

(1) Emergencies are those situations for which no approved individual program plan exists and which if not dealt with may result in injury to the client or other persons or significant amounts of property destruction.

(2) If an emergency occurs the service provider may apply the following techniques as necessary to bring a person's behavior under control:

- (a) Physical restraint;
- (b) Exclusion time-out; or
- (c) Seclusion time-out in a room that conforms to the minimum requirements established by the developmental disabilities program review committee (DDPRC) and, that has been approved by the regional manager prior to use.

The DDP DDPRC Operating Guidelines, and the DDPRC Program Review Checklist documents are available from the DDP upon request. These documents provide more detail regarding the composition of the committee membership, and the protocols used by the committee to approve or deny requests for the imposition of level II aversive programs.

Compliance with the incident reporting policy and the aversive rule is assessed as part of the QA annual review onsite interviews with staff. Specifically, staff will be asked questions designed to assess knowledge of the Administrative Rules of Montana governing the use of physical and mechanical restraint, and other aversive procedures.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

#### b. Use of Restrictive Interventions. (Select one):

**The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

#### ☒ The use of restrictive interventions is permitted during the course of the delivery of waiver services

Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Note- The following ARMs outline the conditions for the use of restrictive procedures in this waiver. Restrictive procedures used by child and family service providers in natural homes are based on the needs and desires of the parent, and agreed upon by the child's planning team. Restrictive procedures are considered procedures of last resort in DDP-funded services.

Safeguards governing the use of non-aversive, level I and level II procedures are outlined in ARM 37.34.1401 through 37.34.1428. Level I procedures are less restrictive than level II procedures, but may not be used unless approved by the planning team. A formal written plan is required. Examples of level I procedures include contingent observation, restriction of social activities and educational finds,

as outlined in 37.34.1410.

Any proposed procedures not classified by rule must be submitted to the DDPRC for classification as either a non aversive, a level I or a level II procedure, as outlined in ARM 37.34.1428. The procedure may be used only in accordance with the rules governing the classified procedure.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The same protections outlined in G-2.b.i. (above) apply, except the DDPRC would not be involved in the review or the approval of procedures classified as non-aversive or level I.

In addition to protections afforded by the formal review of data for behavior support plans as outlined in rule, and the incident management policy (including the compilation and review of data by the incident management committees), the DDP QIS also reviews all programs employing seclusion or exclusion time out, or physical or mechanical restraint, for compliance with the DDP administrative rules applying to the use of Level 2 aversive procedures, as outlined in the applicable performance measure in this section.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

- a. **Applicability.** Select one:

☐ **No. This Appendix is not applicable** (do not complete the remaining items)

☐ **Yes. This Appendix applies** (complete the remaining items)

- b. **Medication Management and Follow-Up**

- i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.
- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

- c. **Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

- i. **Provider Administration of Medications.** Select one:

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- iii. **Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## **Appendix G: Participant Safeguards**

### **Quality Improvement: Health and Welfare**

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

#### **a. Methods for Discovery: Health and Welfare**

*The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.*

##### **i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

Training staff working directly with autistic children must be familiar with the signs and symptoms of abuse, neglect, and exploitation and must know how to report suspected abuse. The numerator is the number of correct survey question answers given by one autism trainer for every child. The denominator is the total number of survey answers by trainer for every served in the waiver.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Children's Autism Trainer staff interview survey results conducted by the DDP QIS.**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	Other Specify:

**Performance Measure:**

Service providers are required to have a comprehensive Incident Management Policy serving to guide the behavior of staff inclusive of the components of the DDP Incident Management Policy. The numerator is the number of reviewed provider agencies with compliant Incident Management Policies. The denominator is the total number of reviewed provider agencies.

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**Review of provider Incident Management Policies by the DDP QIS**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	Other Specify:	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: _____

**Performance Measure:**

**Incident Management Committee Meetings** review documented critical incidents as defined in DDP policy. The numerator is the number of Incident Management meetings held in accordance with the required standards when one or more critical incidents were reported. The denominator is the number of incident management committee meeting that should have been held in compliance with required standards.

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**Review of critical incident reports and Incident Management Committee documentation**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = _____
<b>Other</b> Specify: _____	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: _____
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

Training programs assigned to the children's autism trainer employing exclusion or seclusion time out, or physical or mechanical restraint, will be in compliance with the ARMs governing the use of aversive procedures. The numerator is the sum of clients with training protocols using level II procedures in compliance with Rule. The denominator is the sum of clients with Level 2 procedures.

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

Review of POCs and training protocols for procedures used by the Children's Autism Trainer specifying the use of physical or mechanical restraint, or exclusion or seclusion time out. Related DDP ARMs

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The QA Review Process is the primary mechanism designed to ensure compliance with the performance measures previously outlined. In addition, the review of incident reports, and the review of reports generated by provider incident management committees may result in followup activities by the provider and the assigned the DDP QIS to improve services and to reduce the potential for future incidents.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

In general, many follow up activities are taken by the provider directly when incident reports are circulated in the agency. Incidents that may be considered systemic in nature are often addressed by the agency incident management committees. The DDP QA Review process is ongoing throughout the year for the purpose of addressing systemic or ongoing incident management issues, particularly if those issues have a direct bearing on client health/safety. The Quality Assurance Observation Sheet may be used by the DDP QIS to resolve issues in accordance with agreed upon strategies and timeframes with the provider.

Given the specific nature and purpose of the Children's Autism Waiver, it is expected that the critical and reportable incidents will be less frequent than would be expected in 24/7 paid care giving settings.

**ii. Remediation Data Aggregation****Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Other  
Specify:

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

☒ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

DDP's effort to develop an electronic reporting system under contract with THERAP is ongoing at this time. In the meantime, the DDP is manually entering all critical incident reports in an electronic database. The current database allows DDP staff to review incident information based on a data queries by provider, region, type of incident and other parameters. The DDP produces reports from this database for review and decision making by the DD Quality Council and DDP management.

## **Appendix H: Quality Improvement Strategy (1 of 2)**

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### **Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated,